United Nations A/HRC/39/25

General Assembly

Distr.: General
29 June 2018

Original: English

Human Rights Council
Thirty-ninth session
10–28 September 2018
Agenda items 2 and 3
Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General

Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Summary of the expert meeting on experiences in applying a human rights-based approach to address mortality and morbidity among newborns and children under 5 years of age

Report of the United Nations High Commissioner for Human Rights

Summary

The present report, prepared in accordance with Human Rights Council resolution 33/11, contains a summary of the expert meeting, held on 27 and 28 June 2017, to discuss experiences in preventing mortality and morbidity of children under 5 years of age, with a focus on challenges, best practices and lessons learned, and with consideration of the particular challenges in respect of the newborn child. The expert meeting was organized by the Office of the United Nations High Commissioner for Human Rights in partnership with the World Health Organization.

GE.18-10734(E)

1810734

Please recycle

Contents

		Page
I.	Introduction	3
II.	A human rights-based approach to child mortality and health care	3
	A. Opening and expected outcomes	3
	B. A human rights-based approach to the prevention of child mortality	4
	C. Legal and policy measures to promote rights-based health care	5
	D. Ensuring maximum investment: budget monitoring and financial accountability	7
III.	Improving quality of care through monitoring and accountability	7
	A. Child rights-based quality care	7
	B. Monitoring, evaluation and data to strengthen accountability and quality of care	9
IV.	Strengthening measures for children at heightened risk	10
	A. Addressing newborn and child mortality in situations of conflict and humanitarian crisis	10
	B. Underlying determinants of child mortality	12
V.	Conclusions and recommendations	13

I. Introduction

1. In its resolution 33/11, the Human Rights Council requested the United Nations High Commissioner for Human Rights to organize, prior to its thirty-ninth session and in close collaboration with the World Health Organization (WHO), an expert workshop to discuss experiences in preventing mortality and morbidity of children under 5 years of age, with a particular focus on the implementation of the technical guidance, including challenges, best practices and lessons learned, and including consideration of the particular challenges in respect of the newborn child.

2. The expert meeting, held on 27 and 28 June 2017 at the United Nations Office at Geneva, was attended by 36 participants from all regions, representing United Nations agencies, Governments and civil society organizations, as well as health sector policymakers and practitioners. A background document prepared to guide discussions at the meeting included case studies on how a human rights approach to addressing mortality and morbidity among children under 5 had been approached to date.[1]

3. The expert meeting built upon a body of existing work to address child mortality and morbidity from a human rights perspective undertaken on the basis of mandates given by the Human Rights Council and the World Health Assembly. In its resolution 22/32, the Council invited, inter alia, the Office of the High Commissioner (OHCHR) and WHO to prepare a study on mortality of children under 5 years of age as a human rights concern; in its resolution 24/11, it requested OHCHR and WHO to prepare technical guidance on a human rights-based approach to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31), as well as an initial report on the implementation of the technical guidance (A/HRC/33/23).

4. This substantive work complements the work done by the independent Expert Review Group on Accountability for Women's and Children's Health and the establishment of the Independent Accountability Panel and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). In addition, the adoption of the Every Newborn Action Plan in 2014 by the World Health Assembly has been crucial in drawing attention to the particular needs of the newborn child. Furthermore, the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents, established in May 2016 by WHO and OHCHR, to secure political support for the implementation of the Global Strategy, presented a report of its findings and recommendations in May 2017.[2]

II. A human rights-based approach to child mortality and health care

A. Opening and expected outcomes

5. At the opening session on human rights in the future and the implications for child survival, the United Nations Deputy High Commissioner for Human Rights noted the substantial progress that has been made in recent decades in reducing child mortality; the global number of child deaths had declined from 12.7 million in 1990 to 5.9 million in 2016. Overall progress had been the result of many different factors, including improvements in medical services, technology, advances in immunization and the treatment of childhood infections, as well as the development of standards and respect for human rights. Human rights were intrinsically linked to the realization of the right to health, including the right to education, the right to information, water and sanitation, and the right to be free from violence and discrimination. She stressed that political leadership and commitment, and accountability, were essential to ensure the implementation of the right to

[1] Available at www.ohchr.org/Documents/Issues/Children/ReportExpertMeetingExperiences ApplyingAHumanNov2017.pdf.

[2] WHO and OHCHR, "Leading the Realization of Human Rights to Health and Through Health", 2017.

health. She also noted the importance of child-friendly medical services, and that the rights of the child were being integrated into paediatric standards of care. She welcomed the important contribution made by the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents, and recognized the challenges posed by child marriage to upholding sexual and reproductive health and rights, and the impact of violence and exploitation on the right to health. Too much attention had been focused on the supply side of human rights; there should be greater focus on the voices of people on the demand side of rights, through freedom of expression, assembly and association. She expressed her deep concern at the increasing number of attacks on health workers in conflict situations. A human rights-based approach was fundamental to overcoming powerlessness.

6. The Director of the Department of Maternal, Newborn, Child and Adolescent Health at WHO pointed out the limited implementation of children's rights among health practitioners in spite of the evidence indicating that it improved health outcomes. He emphasized the importance of a human rights-based approach through equality and participation, highlighting the positive role of the 2030 Agenda for Sustainable Development and the Global Strategy for Women's, Children's and Adolescents' Health. He noted the imperative need to interpret certain health practices from a human rights perspective, for example, inadequate access to or overuse of caesarean sections, commercial malnutrition, the marketing of breast-milk substitutes and trade policies that affected health outcomes. He highlighted the broad trends and factors that had an impact on child mortality, such as climate change, lack of political voice, the implications of the global economic model and the failure to implement the Millennium Development Goal on sanitation. Scientific rigour, country leadership and local ownership, social accountability and health education were vital to progress.

7. During the ensuing discussion, participants pointed out that the Sustainable Development Goals presented an opportunity to advance rights, and that good leadership could play a key role where resources were limited. With regard to developing the capacity of rights holders to claim their rights, the High-level Working Group for the Health and Human Rights of Women, Children and Adolescents should be supported, for instance by means of people's councils at the subnational level, given that change on the ground should be local and catalyzed by young people. Some participants asked whether the parameters for child mortality could be expanded beyond 5 years of age, and stressed the challenge posed by inequality, as evidenced by the relatively small drop in mortality for the most marginalized children, including newborns. The issue was closely associated with the fight against gender inequality through the empowerment of girls and women at all levels. Real change should come from citizens' voices and action to hold leaders accountable, and consideration should be given to broader factors, such as the role of fathers, adolescent mothers, the promotion of breastfeeding, commercial malnutrition, and health professionals who did not have a human rights focus. Legal approaches, including to combat marketing of breast-milk substitutes, could be supported by behavioural change programmes, as had been demonstrated in the implementation of anti-tobacco laws.

8. The Chief of the Right to Development Section at OHCHR stated that the central objective of the meeting was to learn from specific examples of how a human rights-based approach had an impact on the prevention of mortality and morbidity of newborns and children under the age of 5, with a view to strengthening the integration of this approach among practitioners and policymakers. The meeting provided a platform for the discussion of challenges, best practices and lessons learned among expert participants, and would explore how and to what effect the implementation of the technical guidance could have an impact on reducing child mortality.

B. A human rights-based approach to the prevention of child mortality

9. The Child Rights Adviser at OHCHR referred to the international framework for the protection of children's rights and the core elements of a human rights-based approach, namely, participation, accountability, non-discrimination and equality. The right to health was a universal right, enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights and article 24 of the Convention on the Rights of the Child. She

referred to the different elements of the right to health, including availability, accessibility, acceptability, affordability and quality, and underlined the importance of ensuring access to remedies to support the process of claiming the right to health. Article 24 of the Convention on the Rights of the Child referred not only to the obligation of States to take steps to reduce infant and child mortality, but also requested States parties to take all measures to abolish traditional practices that are prejudicial to children's health; these included child marriage and female genital mutilation. According to international human rights law, States were obliged to implement the right to health to the maximum of their available resources. The idea of securing human rights to health and through health should be pursued further. She outlined the core challenges that had an impact on child mortality with regard to birth registration, children in situations of migration, and the imperative to prioritize the rights of the newborn child.

10. Laura Ferguson from the Program on Global Health and Human Rights at the Institute for Global Health (University of Southern California) presented an overview of, and lessons emerging from, the case studies identified in her research, including case studies shared prior to the meeting by expert participants. She discussed the relationship between legal human rights obligations and the importance of evidence in paediatrics. While discussing the findings of the case studies, she highlighted the imperative of accountability, data and monitoring, and concluded that a human rights-based approach could be applied to mortality and morbidity of children in diverse ways, with highly positive results. Beyond the legal imperative to implement a child rights-based approach, such an approach was extremely promising and could contribute to better health outcomes. A stronger base of evidence to demonstrate this could increase the attention paid to rights-based approaches and support the realization of children's rights and their health.

11. According to some participants, health workers could be promoters of rights, and should be protected and supported by means of training and education, which would enable them to claim their own rights and deliver quality care. There was also a need to address social norms and the determinants of health; a holistic life cycle approach should be applied, including due attention to the role of women and violence against them, which had a major impact on rates of child survival. When considering how to realize rights through health, participants stated that it was essential to examine health inequities, and that rights could be realized through health in diverse ways, depending on the context, such as in cross-border and migration situations. Participants emphasized the ways in which power dynamics played a role in health outcomes, and called into question legalistic applications of human rights, noting that, in the case of South Africa, access to antiretroviral therapies had been won by pursuing legal rights also through political engagement.

C. Legal and policy measures to promote rights-based health care

12. Haroon Saloojee of the University of the Witwatersrand, Johannesburg made a presentation on a landmark judgment in support of child rights in South Africa. He noted that arguments had been put forward against providing anti-retroviral drugs to prevent mother-to-child transmission of HIV, one of which was their cost. Political action had been taken at the grass-roots level, followed by legal action to force doctors to prescribe those drugs. Following a court case that found that failure to provide anti-retroviral drugs was a violation of the constitutional right to basic health care, the High Court ordered the Government to begin a countrywide mother-to-child transmission prevention programme. In the decade following the court case, half a million infants were saved and transmission rates dramatically decreased. This case demonstrated that successful litigation on human rights required respect for the rule of law, a Government willing to prioritize constitutional rights, and an active civil society willing to challenge the Government.

13. Suzanne Aho, member of the Committee on the Rights of the Child and former Minister for Health of Togo, discussed the legal and policy measures taken to combat newborn and child mortality in Togo. Despite the shortfalls in funds allocated to health, it remained a national policy priority. In the efforts made to reduce infant and maternal mortality, one ongoing challenge were the unofficial clinics that claimed to treat mothers and newborns but that neither followed medical procedures nor had adequate equipment. In

addition, medical professionals did not know which drugs should be provided free of charge, and public awareness programmes had been ineffective owing to their lack of local engagement. Despite the adoption of a law in 2012 on measures to prevent neonatal and maternal deaths, its implementation had been limited owing to the lack of access of pregnant women and newborns to health care and services, public scepticism with regard to vaccines, low rates of birth registration, and challenges in the regulation of drug markets.

14. Helia Molina of the University of Santiago stated that, in the 1950s, awareness that the rate of infant mortality was problematically high began to grow, and national action was taken to reduce it. Even though per capita income in Chile was low, the targeted national efforts made had led to a massive reduction in the child mortality rate by 2014. Public expenditure on health was still among the lowest (3.4 per cent of GDP against an average of 6.5 per cent in countries that are members of the Organization for Economic Cooperation and Development), which showed that there was no direct correlation with expenditure. What was important was the focus on primary health-care issues and targeted, long-term policy planning implemented through comprehensive approaches. Success also relied upon strong political will and the development of human resources and capacity.

15. David Sanders from the University of Western Cape (South Africa) addressed the evidence, experience and regulatory challenges in ensuring access to essential child health interventions. In South Africa, rates of child mortality were, considering the country's level of wealth and development, higher than they should be because of a lack of momentum, fragmentation, and inadequate resources. Immunization coverage for babies was also well below what it should be, given the country's income level, owing to a shortage in vaccine stocks, the sheer distance to clinics and low degree of awareness among mothers. Interest in the role of community health workers had, however, been renewed, and community case management had been introduced to address pneumonia, a major cause of child mortality. All countries that had managed to attain the targets of Millennium Development Goal 4 on child mortality had community health workers; in South Africa, however, there was still only one community health worker for every 250 households.

16. Marcus Stahlhofer of WHO discussed addressing inappropriate marketing of breast-milk substitutes and other foods for infants and young children, including through human rights frameworks. Improved breastfeeding rates worldwide could save the lives of as many as 823,000 children under 5 years of age, result in economic gains of more than $300 billion annually due to increased productivity, and lead to a 6 per cent reduction in the risk of invasive breast cancer. Women, however, lacked support to initiate and sustain breastfeeding, and investments in this regard fell far short. Global annual sales of breast-milk substitutes totalled $44.8 billion, and were expected to rise to $70.6 billion by 2019. Even though the International Code of Marketing of Breast-milk Substitutes, adopted by WHO in 1981, was a major instrument in protecting mothers and babies from inappropriate marketing of breast-milk substitutes, its implementation at the national level remained low: only 35 States had comprehensive Code-related legislation, and only 32 States had a functional monitoring and enforcement system in place for implementation of laws. Manufacturers of breast-milk substitutes continued to interfere in both law-making and policy development, while lack of political will, data and coordination posed problems too. Moreover, legislation, monitoring and enforcement were inadequately resourced. Such action (and lack of action) constituted a violation of mothers' and children's rights. International human rights institutions should be part of the solution.

17. During the discussion, participants considered the importance of the availability, accessibility, acceptability and quality of health services. They noted that litigation could be a catalyst in this respect, but that its effectiveness could be reduced by corruption and clientelism. They discussed the reasons for the delays in the progress made in the fight against child mortality, which in some cases included the late booking of pregnancies, inadequate postnatal follow-up, lack of household visits from health workers and lack of data, including on deaths outside health facilities. Mental health issues and substance abuse, neglected in most countries, also exacerbated the situation of child mortality. Participants agreed that greater efforts were needed to support breastfeeding, including through civil action to strengthen a culture of breastfeeding. They proposed that violators of the WHO

International Code of Marketing of Breast-milk Substitutes could be named on an annual list.

D. Ensuring maximum investment: budget monitoring and financial accountability

18. Bob Muchabaiwa of the United Nations Children's Fund (UNICEF), Ethiopia pointed out that investment in children was a rights issue, given that it was the means through which core challenges to child rights were targeted. There was a positive correlation between increased health expenditure and reductions in mortality rates, where fiscal policies supported access to and the availability, affordability and quality of health care. In this respect, the use of disaggregated data and statistics in defining budgets was fundamental to ensure responsiveness to key age and gender considerations. Corruption was a challenge, as it led to the wasting of large amounts of resources allocated to health, while low levels of financing in emergencies resulted in higher rates of mortality and morbidity. Health budgets could be buttressed by tackling inefficient expenditure and by ensuring cost-effective management of procurement, together with fiscal transparency, budget monitoring and greater social accountability. Focus should be strengthened on the political economy dimension, the links between policy plans and budgets on the basis of children's rights, a greater reliance on sustainable domestic resources, and investment in community health care.

19. Participants stated that an effective legal framework on health should be accompanied by corresponding financial plans. While policies were compliant in most countries, major shortfalls undermined implementation. Ensuring adequate resource allocations was a key factor in implementing laws and policies, and children should be able to give their opinion on these matters in appropriate forums. Trade-offs (though contentious) were sometimes made between the application of a purely economic model and of a rights-based model; Governments therefore had to find a balance between them. Private health care in poor countries undermined the overall quality of public health systems by serving as a refuge for those who could afford it.

III. Improving quality of care through monitoring and accountability

A. Child rights-based quality care

20. Andrew Clarke of Lancashire Care NHS Foundation Trust (United Kingdom of Great Britain and Northern Ireland) and Kidasha (United Kingdom and Nepal) discussed the development of tools and approaches to measure children's rights in health settings and to improve the quality of care. He explained that human rights were often violated in health-care settings, and elaborated on the lessons learned from projects in Nepal based on standards contained in the Convention on the Rights of the Child, which made children's rights part of daily health practices, including through support for health workers and by providing a framework to monitor and improve the quality of care. In Nepal and Chile, human rights were a greater concern in primary care than in most countries; in the *Hospital Amigable* ("Friendly Hospital") programme in Santiago, child rights had been adopted as the mission strategy of the hospital. This case demonstrated that a human rights-based approach could guide health planners and support health workers, improving the experience of care and reducing suffering. Pragmatic tools that could be integrated into routine health practices were needed, and health workers should be enabled to design rights-based improvements to quality of care through training and facilitation.

21. Ana Isabel Guerreiro, an independent consultant, presented her perspective on improving quality of care in hospitals through human rights-based standards. She explained that the Convention on the Rights of the Child could be used as a functional framework to guide the development and delivery of human rights-based health care to children, and pointed that equality, participation and accountability were key principles in this respect.

She stressed the need for a concurrent focus on the wider enabling environment; for example, in WHO pilot programmes to implement quality of care tools in health systems in Georgia, the Republic of Moldova and Tajikistan, a broader goal was to support reporting on the implementation of health-related and other rights under the Convention. She provided examples of standards for assessing and improving children's rights, for example by defining the best possible quality of care that could be delivered to all children, or developing plans to ensure equality and non-discrimination. The integration of child rights and quality of care standards into relevant undergraduate and graduate curricula was crucial.

22. Raul Mercer of the Program of Social Sciences and Health at the Latin American School of Social Sciences (FLACSO), Buenos Aires delivered a presentation on capacity-building and child rights training for health practitioners. He pointed out that the main determinants of health were only 10 per cent medical and 90 per cent due to social and environmental factors. In order to effect change, scientific evidence should be translated with a rights-based approach; a continuum of rights throughout life should be established through, inter alia, the promotion of human rights, the prevention of violations and the restitution of rights. With regard to training health professionals, epidemiological information could be used as the foundation of a national rights-based policy. Barriers in health systems and interventions, including bias, discrimination, omission, homophobia, prejudice and racism, ought to be addressed.

23. Armida Fernandez of the Society for Nutrition, Education and Health Action (SNEHA), Mumbai (India) discussed ways of tackling challenges to quality care in low-income areas, such as ensuring sustainability. Her work focused on women and children, given that they were the most vulnerable groups in slums. The application of a life-cycle approach to the prevention of violence against women was essential. Almost half of the 16 million inhabitants of Mumbai lived in slums, where many women gave birth in their home. Gaining the trust of communities and changing health-seeking behaviour while accounting for diverse cultures and traditions had posed a real challenge. To bring about changes to behaviour, SNEHA had implemented a capacity-building and monitoring programme for community health workers. India had a mixed public and private health-care system, where partnerships had played a key role, including with private companies, public institutions and the global academic community. An appreciative approach to inquiry had been taken in order to share the strengths of successful approaches identified in workshops held with administrators, doctors, nurses and others. Access to the poorest had been improved by installing neonatal clinics at local health posts, where a referral system to peripheral and maternity hospitals had been developed. Improving the quality of care required partnerships, perseverance and a participatory approach.

24. Tarek Meguid of the Mnazi Mmoja Hospital and the State University of Zanzibar presented his perspective on the feasibility of high-quality maternal and child health care in hospitals in Zanzibar. He described a project designed to assess the readiness of local hospitals to integrate a human rights-based approach to quality of care on the basis of WHO standards. At the largest hospital in Zanzibar, which delivers 13,000 babies every year, infrastructure and services were scarce owing to problems with supplies, staffing and poor standards of care. Health workers were uninformed about rights; training and capacity-building were therefore needed to implement quality care standards. Men should be more involved during and after deliveries, but were prevented from doing so. Patients deserved dignity, and could play a key role if empowered to voice their needs. He emphasized the importance of addressing determinants to strengthen health-care systems, and of addressing the political context to bring about justice.

25. Sanjay Atreya of the Asha Health Care programme (Child Welfare Scheme Nepal) made a presentation on integrating children's rights into the design and delivery of primary care services in western Nepal. He explained that primary care was a key opportunity to integrate human rights, and highlighted its shortfall among the urban poor, leading to, inter alia, violations of rights and hospital services that were unaffordable, and consequently little used or delayed. Many private providers were unregulated, their services just as unaffordable and associated with low quality care. A network had been created to improve primary health care and to make it more accessible, with a view to designing systems and

delivery based on human rights, and to increase the use of services by the poor, the socially excluded and disadvantaged castes. Efforts had led to major improvements in health-seeking behaviour, as confirmed by quality indicators. Care delivery was focused on values, behavioural change, training, protocols and monitoring. The approaches taken in this initiative had been adopted in the local municipal health-care systems in 2016.

26. During the discussion, participants considered how rights could be employed from the perspective of (a) legal frameworks and institutions that support the delivery of care through requirements enabling human rights input to health systems; and (b) accountability through the use of quality care benchmarks demonstrating the user's perspective. They stressed that the issue of discrimination deserved greater attention, given that discriminatory barriers to health care were a central challenge that led to adverse health outcomes. They reiterated that the rights of health service providers should be addressed, and not only the rights of patients, given that, in many cases, the conditions of health-care workers amounted to a violation of human rights. "On the ground" mechanisms were imperative; changes should be accompanied by corresponding protocols. Education and training played a key role, also for health-care professionals on health-related laws. There was in addition a need for a greater focus on care and education provided to women, to ensure that mothers were empowered by relevant knowledge and information.

27. While some participants advocated for the expanded use of randomized controlled trials, others pointed out that they were costly and might not be an appropriate research methodology to gather evidence on the human rights dimension; they proposed that such funds could be used instead for alternative types of research, such as implementation research, including how to better implement effective measures that already existed, and how to develop additional tools and metrics to improve human rights-based approaches to child mortality. The right to privacy starts from the very outset; there was evidence that showed that the prognosis for newborns improved when the right to privacy was respected in intensive care units for newborns.

B. Monitoring, evaluation and data to strengthen accountability and quality of care

28. Dinesh Poudyal of the Namuna Integrated Development Council (Nepal) discussed human rights in public health and social approaches for improving child health and accountability. He explained that gender and social discrimination were barriers to improving health in Nepal, exacerbated by lack of knowledge and information, poverty, difficulty in gaining access to health care and a lack of local accountability. In a three-year project encompassing caste-disadvantaged communities experiencing the highest rates of child mortality, progress had been made by addressing the infrequent use of maternal, newborn and child services by marginalized groups and negative gender norms and by promoting the empowerment of pregnant women. Positive change had been eventually made in the district health system, particularly by embedding local accountability systems and emphasizing a rights-based approach to health care.

29. Prasanta Tripathy of Ekjut India addressed the role of monitoring to strengthen community-based newborn health strategies. His organization implemented participatory learning and action through community mobilization and capacity-building workshops to improve maternal and newborn health, in accordance with WHO recommendations. After 10 to 12 group meetings, women felt confident to take on society and government officials in seeking support to improve outcomes. Although the change process had been difficult owing to established, hierarchical ways of working within the health system, the evidence gathered through a monitoring system reflected major reductions in mortality by the second year of implementation. Looking at the data from the perspective of inequality, participatory groups generated the greatest impact for the poorest, as they addressed social determinants and were conducted in local dialects. They had found that neonatal mortality could only be reduced if the poorest rural homes were reached by community health workers. The impact of participatory learning and action interventions had been sustained over time, even though the specific pathways to results had changed over time.

30. Nand Wadhwani from the Mother and Child Health and Education Trust (India) delivered a presentation on the opportunity provided by new technologies to increase access to health-care knowledge. He highlighted the fact that most deaths of infants under 5 years of age were from treatable and preventable causes, and that a lack of basic health-care knowledge cost lives. He stressed the need to ensure that mothers knew about basic health care; currently, pregnant women received little to no health information. Despite the inadequacy of health-care budgets, the advent of smartphones and mobile technology today allowed health knowledge to be brought directly to those who need it most, bypassing complex administrative structures. The vision of the Mother and Child Health and Education Trust was to give every woman, when she registers her pregnancy, access to a video library, in her own language, containing information on the importance of the first 1,000 days of pregnancy, starting from pregnancy. The library could serve as an instruction manual for the entire pregnancy and help mothers to be in contact with health-care professionals.

31. Laura Ferguson of the Program on Global Health and Human Rights, Institute for Global Health, University of Southern California, presented her perspective on using routinely collected child health data for monitoring human rights and on ensuring sustainable approaches to collecting human rights data. She provided an overview of a human rights-based approach, and emphasized the importance of relying on data, and in particular disaggregated data, to strengthen the implementation of a human rights-based approach in health systems. She pointed out that human rights evaluations were complex; there was therefore a need for interim indicators to help to identify specific pathways and theories of change. She outlined a framework for assessing the extent to which existing child health indicators could shed light on the realization of human rights, and highlighted how findings could be used to inform national and subnational data-collection efforts. She underscored the need to ensure the local relevance of all data to help to ensure that they were used to inform improved service delivery with a view to improving child health and the realization of children's rights.

32. Participants discussed how monitoring and measuring progress was central to addressing discrimination and inequalities, and debated the role and limitations of randomized controlled trials. Some stressed the importance of community-based monitoring and of data that captured elements absent from routine hospital data, which were easy to collect but uninformative on human rights indicators, such as accessibility and acceptability. One participant pointed out that data were usually not disaggregated and could be subject to double counting, such as on immunization coverage in South Africa. Routinely collected household survey data also did not generate qualitative human rights data, and there were limits to what could be collected through household surveys. Participants added that special monitoring methods and disaggregated data collection were necessary in health facilities alongside qualitative research to reflect human rights dimensions. Primary and secondary health-care facilities should be integrated, and more investment made in community health interventions and their assessment. In this context, engaging men to combat gender barriers and monitoring pregnant women correctly were essential.

IV. Strengthening measures for children at heightened risk

A. Addressing newborn and child mortality in situations of conflict and humanitarian crisis

33. Roberta Petrucci of Médecins sans Frontières (Switzerland) gave an overview of the impact of conflict and emergencies on children's health. She explained that one in six children lived in countries affected by conflict, that more than a third of child deaths were in countries affected by conflict and emergencies, and that 50 per cent of all refugees were children. Displaced children had a greatly heightened risk of mortality, and children were disproportionately affected by terrorist attacks and actively recruited into armed groups. Complex factors beyond the medical realm led to high rates of child mortality in conflict and humanitarian crises, such as lack of access to water and sanitation, exposure to malaria

or other illnesses, and lack of access to food or health-care facilities. The response necessary was therefore not only medical. As seen recently in the Syrian Arab Republic and Yemen, health-care facilities, hospitals and humanitarian convoys were increasingly targeted to destabilize areas, and children faced the long-term consequences of trauma, including post-traumatic stress disorder, anxiety and depression, even after the conflict had ended.

34. Jérôme Pfaffmann, a child health specialist at UNICEF, delivered a presentation on community health in emergencies. He explained that emergencies, conflict and humanitarian crises were among the greatest threats to realizing children's right to health. There was a need for a detailed understanding of the challenges in each emergency to ensure an appropriate response. He stressed the importance of community health workers embedded in the local population, and of integrated primary health-care systems. He referred to UNICEF case studies from experience in Guinea, Liberia and South Sudan, highlighting how community health workers had been able to continue their work even when formal health system services had been disrupted. Community health workers needed ongoing support in order to operate effectively throughout crises and emergency situations. Greater investment was needed in predicting crises and in planning effective responses, including tools for applying a human rights-based approach.

35. David Southall of Maternal Child Health Advocacy International (United Kingdom of Great Britain and Northern Ireland) delivered a presentation on the topic of protecting children from the health consequences of armed conflict. He stated that the nexus of security, insecurity and health must take precedence in crisis settings; international law was, however, ignored in conflict, and the situation was worsening globally. Attacks against health facilities and health workers were endemic (as in for example Somalia); the Security Council, in its resolution 2286 (2016), urged States to address such attacks and to take action to ensure accountability for perpetrators. He noted that, in May 2017, the Safeguarding Health in Conflict Coalition published a report documenting the current situation and showing that such attacks were continuing globally, not only in the Syrian Arab Republic and Yemen, but also in Afghanistan and elsewhere. The proliferation of arms — including those manufactured by States Members of the Security Council — was a primary contributing factor to conflict, and proposed the development of a targeted global health protection system, funded and managed by the United Nations.

36. Nour Alnirabia of the Syrian American Medical Society Foundation in Aleppo made a presentation on her experience of addressing newborn and child mortality in the Syrian Arab Republic. She stated that children in conflict zones had heightened needs owing to displacement, injuries and lack of health care due to the destruction of medical centres and the lack of adequate personnel, facilities and equipment to cover the population. In the Syrian Arab Republic, for each physician there were 6,000 children needing care. Newborns, particularly premature babies, were at greatest risk of mortality; nonetheless, 300 babies were delivered daily in areas where hospitals did not have the means to provide care. Patients had no access to facilities being targeted by bombings and from which children were removed for safety reasons, even though they needed treatment. Chemical attacks were committed in areas where children could not be treated, and a lack of vaccination coverage in Syrian conflict areas had recently led to a polio epidemic. Children needed support through education, orphanages and centres to recover from the psychological trauma and stress of living through conflict, and also safe schools, which could help to build the next generation.

37. During the discussion, participants pointed out that attacks on health facilities in conflict were one of the six grave violations of children's rights that the Human Rights Council had been mandated to address. While minimum standards existed for humanitarian responses, they did not exist for children in emergency situations. There was a need to address how children's health was prioritized in humanitarian response planning; an inter-agency subcluster could be considered. More detailed understanding was needed in order to respond to non-medical factors, including underlying determinants, such as malnutrition. Participants noted the large number of abortions and premature births due to the exposure of pregnant women to conflict situations, and that conflicts of interests of States were an obstacle to bringing about effective responses to conflict.

B. Underlying determinants of child mortality

38. The Special Rapporteur on the right to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, stated that although remarkable achievements had been made in the right to survival globally, the right to holistic health and development was equally important. Healthy and responsible adults, including parents, were instrumental to breaking the cycles of violence and hopelessness. He pointed at asymmetries in health-related policies and approaches that were often too medicalized, adding that greater attention to underlying social determinants was needed in order to realize the right to health. He pointed out that non-biomedical interventions, such as psychosocial interventions, were also very effective, and highlighted a thematic report addressing the human rights of infants and newborns, who were also equal rights-holders deserving of dignity. Retrogressive measures globally with respect to women's rights were cause for great concern. The Special Rapporteur then stressed the importance of implementing the right to health while also realizing rights as a means of attaining health outcomes.

39. The Special Rapporteur on the human rights to safe drinking water and sanitation, Léo Heller, underscored how underlying determinants were key factors in addressing child mortality, and the well-documented relationship between improving water and sanitation and child health. If water, sanitation and hygiene measures were improved, the incidence of diarrhoea could be reduced by 25 per cent, and child mortality by up to 65 per cent. Initiatives to improve the supply of water and sanitation services that were based on the human rights framework had the greatest impact. Hand-washing with soap could reduce cases of diarrhoea by up to 50 per cent. Regular access to safe drinking water prevented unsafe storage practices, and its supply to schools and health facilities was a key to child health. The Special Rapporteur had observed in several countries unaffordable systems for providing water and sanitation in urban areas. For successful outcomes, affordability was therefore essential.

40. According to the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes, Baskut Tuncak, there was currently a human rights crisis due to exposure to toxic chemicals and wastes, responsible for substantial mortality rates of children under 5 years of age, with serious effects for their development. Paediatricians had referred to a silent pandemic that started before babies were born. Childhood diabetes, cancer, impaired neurological development and asthma all pointed back to exposure to hazardous substances and waste. In his report on trends in this regard (A/HRC/33/41), the Special Rapporteur had explained that States had a duty to prevent childhood exposure, which violated different rights at multiple levels. Children could be irreversibly affected by exposure from very early in life. As policymakers could not pinpoint the risk factors causing high disease rates, no rights violations were identified, so no action was taken. The poorest were discriminated against because they were subjected to the greatest degree of exposure, but had no access to their rights. A new policy perspective was required, beyond risk assessment, where States could (a) assess toxic threats and prevent exposure; (b) require that businesses conduct human rights due diligence assessment; and (c) implement an effective global framework of treaties on hazardous substances and wastes.

41. The discussion focused on cross-cutting issues affecting underlying determinants, including behavioural change through access to information. All people, including children, had a right to be properly informed through health education and information. Rights relating to essential resources and a healthy environment were a question of equality and non-discrimination; States therefore had to provide effective protection to children in this regard. Participants asked how the value of human rights could be demonstrated through relevant data, tools and arguments, and noted that general comment No. 24 (2017) of the Committee on Economic, Social and Cultural Rights on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities would be informative on the obligations of States and the responsibilities of private companies.

V. Conclusions and recommendations

42. Most child deaths are witnessed in the most marginalized communities and regions. Preventing child mortality therefore requires effectively tackling health inequality and overcoming the barriers and multiple forms of discrimination that exist in health systems and communities. Children face heightened risk in certain circumstances, such as migration or displacement, and at critical life-stages, particularly when they are newborn. Child mortality increases sharply in situations of conflict and humanitarian crisis, and underlying determinants — such as exposure to hazardous substances and waste, or lack of access to clean water and sanitation — can cause mortality rates to rise substantially.

43. There is growing evidence that a human rights-based approach to health care, as well as being an obligation of States under international law, contributes to improved child mortality outcomes. The case studies presented at the meeting indicated that such an approach can guide health planners and support health workers in improving the quality of care. Awareness of human rights or their implementation by health practitioners is, however, limited. A strengthened evidence base is required to convey the value of a human rights-based approach to preventing child mortality. There is a need for monitoring health outcomes on the basis of disaggregated data, including qualitative data on human rights indicators, such as the accessibility and acceptability of care. A life-cycle approach in which women are engaged and empowered at all stages and gender-based violence is tackled as a priority is critical.

44. The links between legal frameworks and policy plans should be strengthened, alongside greater investment in children's health. Existing health resources can be maximized by tackling corruption and supporting social accountability. As political will, incentives and power structures — including commercial interests — are key factors, legal and political action should be pursued in parallel in order to bring about transformative results.

45. Taking concrete measures to ensure accountability and participation improves the quality of care. Quality of care benchmarks in health systems, greater participation of patients, particularly women, and accessible and effective mechanisms for redress all contribute to accountability. Quality improvement tools for maternal, newborn and paediatric care recently developed by WHO integrate principles and standards relating to children's rights; their application is expected to provide a greater insight into how human and child rights can make a positive contribution to respectful and dignified care for children and their caregivers.

46. Any attack on health facilities in conflict is a grave violation of child rights, and the increase in such attacks violates the right to life and the right to health for children. An international protection system should be established for health workers and facilities in conflict and situations of humanitarian crisis.

47. Non-medical factors can have a major impact in exacerbating child mortality rates; a focus on the underlying determinants of health, including social norms, is therefore crucial. In certain circumstances, addressing underlying determinants requires challenging practices adopted by the private sector, for example, in the marketing of breast-milk substitutes, the privatization of access to clean water and the management of hazardous substances and toxic waste. In this respect, States have an obligation to ensure that private actors fulfil their responsibility to respect children's rights.

48. States could consider establishing a United Nations inter-agency working group to take forward the key recommendations made at the meeting with respect to the application of a human rights-based approach to address mortality and morbidity among newborns and children under 5 years of age.

United Nations A/HRC/39/26

General Assembly

Distr.: General
29 June 2018

Original: English

Human Rights Council
Thirty-ninth session
10–28 September 2018
Agenda items 2 and 3
Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General

Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Follow-up on the application of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity

Note by the Secretariat

Summary

The present report highlights initiatives related to the application of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity. The report also offers observations on the application of a human rights-based approach to reduce preventable maternal mortality and morbidity in humanitarian settings.

GE.18-10756(E)

1810756

Please recycle

Contents

		Page
I.	Introduction	3
II.	Dissemination and promotion activities	3
III.	Utilization of the technical guidance	4
	A. National level multi-stakeholder processes	4
	B. Legislation, planning and budgeting	5
	C. Programmes and capacity-building	5
	D. Monitoring, review, oversight and remedies	6
IV.	Challenges for the implementation of the technical guidance	6
V.	Application of a human rights-based approach to humanitarian settings	7
	A. Overview	7
	B. Key elements	11
VI.	Recommendations	16

I. Introduction

1. In September 2012, the Human Rights Council adopted its resolution 21/6, in which it welcomed the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes for the reduction of preventable maternal mortality and morbidity. Two follow-up implementation reports were produced, in 2014 (A/HRC/27/20) and in 2016 (A/HRC/33/24). In September 2016, in its resolution 33/18, the Council requested the Office of the United Nations High Commissioner for Human Rights (OHCHR) to prepare a report on good practices and challenges in the application of a human rights-based approach to the elimination of preventable maternal mortality and morbidity, including through the utilization of the technical guidance. The present report is submitted in response to that request.

2. At the request of the Council, OHCHR organized a panel discussion in March 2017, during the thirty-fourth session of the Human Rights Council, which provided an opportunity to highlight positive initiatives to address maternal mortality and morbidity from a human rights perspective. The discussions pointed to the need for stronger accountability for the realization of human rights in the context of maternal health, and sexual and reproductive health more broadly.

3. Drawing on submissions received by a wide variety of stakeholders,[1] the present report highlights initiatives, good practices and challenges related to the implementation of the technical guidance and a human rights-based approach more generally.

4. The second section of the report examines the application of a human rights-based approach to reduce preventable maternal mortality and morbidity in humanitarian settings, a dimension that was not the focus of the technical guidance. As the majority of preventable maternal deaths have occurred in settings of conflict, natural disasters and displacement, there was a need to further consider how a rights-based approach would contribute to humanitarian efforts. The present report takes a first step in that direction.

II. Dissemination and promotion activities

5. Efforts to disseminate the technical guidance continued from 2016. Around the world, the guidance was referred to in numerous publications, reports and documents and was also widely disseminated and promoted by stakeholders.[2] The International Planned Parenthood Federation and the Swedish Association for Sexuality Education utilized their global networks to raise awareness of, seek information on and advocate for its implementation.[3]

6. OHCHR continued its work to disseminate the technical guidance through briefings, workshops and bilateral engagements with States and other stakeholders at the national, regional and international levels.

7. The technical guidance formed a key component in the advocacy of OHCHR in the context of the 2030 Agenda for Sustainable Development, including its promotion during

[1] For the complete list of submission, please visit: www.ohchr.org/EN/Issues/Women/WRGS/Pages/FollowUpReport2018.aspx.

[2] See Independent Accountability Panel, *Old Challenges, New Hopes: Accountability for the Global Strategy for Women's, Children's and Adolescents' Health* (2016), p. 9; World Health Organization (WHO), *Monitoring human rights in contraceptive services and programmes* (Geneva, 2017); B. Mason Meier and L.O. Gosti (eds), *Human Rights in Global Health* (Oxford University Press, 2018); E.A. Friedman, "An Independent Review and Accountability Mechanism for the Sustainable Development Goals: The Possibilities of a Framework Convention on Global Health", in *Health and Human Rights Journal* (June 2016), pp. 129–140; P. Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health", in *Health and Human Rights Journal* (December 2016), pp. 109–130.

[3] See also submissions by UNFPA Uganda and Roda.

the high-level political forum. It was furthermore instrumental in shaping the actions of OHCHR to meet and report on its commitments to the World Humanitarian Summit. The Committee on Economic, Social and Cultural Rights, the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child also continued to call on States parties to implement the technical guidance in their concluding observations.

8. In an effort to make the guidance more accessible for specific stakeholder groups, OHCHR — in collaboration with the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the Partnership for Maternal, Newborn and Child Health and the François-Xavier Bagnoud Centre for Health and Human Rights of Harvard University — produced practical guidance for the judiciary on key considerations in applying a rights-based approach to sexual, reproductive, maternal, newborn and under-5 child health.[4] This adds to the series of reflection guides highlighted in previous reports, including for health policymakers, national human rights institutions and health workers.

9. OHCHR worked closely with other United Nations agencies to integrate the technical guidance in wider United Nations processes, notably the Global Strategy on Women's, Children's and Adolescents' Health, including through the convening of the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents, established by WHO and OHCHR. In its report,[5] launched in May and June 2017 at both the World Health Assembly and the Human Rights Council, the Working Group put forward a holistic, integrated approach, asserting that the health of women, children and adolescents could only be improved if human rights were upheld and if there was strong political will and leadership. As a result of the work of the Working Group, WHO and OHCHR concluded a framework of cooperation and are developing a joint programme of work to support further implementation of the recommendations, which will include efforts to further promote implementation of the technical guidance.

III. Utilization of the technical guidance

A. National level multi-stakeholder processes

10. The technical guidance supports the convening of multi-stakeholder processes to consider and prioritize action on human rights related to sexual and reproductive health, and OHCHR has facilitated such processes with partners since the adoption of the technical guidance.

11. For instance, in Malawi, following the 2015 multi-stakeholder dialogue on the human rights assessment and national inquiry, efforts continued to implement the action plan that emerged from that process. The follow-up efforts included: monitoring implementation of the recommendations; working towards accountability through dissemination meetings in 10 districts; providing training to strengthen the capacity of service providers; and establishing real-time reporting and early warning signs of violations of sexual and reproductive health and rights. Those processes also supported legislative reform efforts, such as increasing the age of marriage to 18 years and revisions to the national sexual and reproductive health policy, which raised budget allocations for contraception and sets out a strategy for strengthened community and youth-based sexual and reproductive health initiatives. That work, which was supported by UNFPA, was coordinated by a national task force, established by the Malawi Human Rights Commission and composed of civil society organizations and State institutions.

12. Following the 2014 multi-stakeholder consultation in Uganda, OHCHR continued to work closely with the Ministry of Health, UNFPA, WHO, the Uganda Human Rights Commission and civil society on the technical guidance, including support to the Ministry of Health in the development and elaboration of its multi-sectoral strategy on the

[4] See www.ohchr.org/Documents/Issues/Women/WRGS/JudiciaryGuide.pdf.

[5] Available at www.who.int/life-course/publications/hhr-of-women-children-adolescents-report/en/.

application of a rights-based approach to reduce preventable maternal mortality and morbidity, which was nearing completion. The strategy was based on a synthesis report produced in 2017 that reviewed existing multi-sectoral programmes and initiatives from a human rights perspective and highlighted a number of systemic challenges, including: insufficient coordination and gaps in human resources for emergency obstetric care; inadequate funding for medical equipment, tools and medicines; and inadequate information management at the district level. The strategy sought to address those challenges from a human rights perspective.

13. Multi-stakeholder initiatives to implement a rights-based approach to sexual and reproductive health were highlighted by States and civil society organizations in their submissions. For instance, Croatia noted collaborative efforts across sectors to elaborate regulatory frameworks and with non-governmental organizations to advance respectful sexual and reproductive health care. Human Rights in Childbirth convened multi-stakeholder meetings and conferences around the world to discuss barriers to accessing life-saving care and the quality of care in birth facilities.

B. Legislation, planning and budgeting

14. In their submissions, several States and UNFPA reported how the human rights-based approach had been drawn on in legislative initiatives concerning maternal mortality and morbidity.[6] The Democratic Republic of the Congo, in its submission, emphasized how it had used the technical guidance to inform the development of its proposed law on universal health coverage.

15. The United Nations country team in Malawi supported awareness-raising efforts concerning the magnitude and implications of unsafe abortion in support of the termination of pregnancy bill, which aimed to expand the grounds where abortion was permitted and was under consideration by the relevant authorities.

16. A number of States described in their submissions how they had adopted aspects of the technical guidance in their national strategies.[7] In Uganda, various local district governments had also committed to prioritizing budget allocations for maternal health programmes. Attention to the most marginalized population groups and their inclusive participation in the planning and budgeting process was also emphasized by civil society organizations.[8]

C. Programmes and capacity-building

17. Numerous programmes and capacity-building initiatives were undertaken in line with the technical guidance and the human rights principles. Some stakeholders, such as Sweden and Turkey, highlighted health interventions specifically destined for women who faced socioeconomic barriers.[9] International Planned Parenthood Federation also implemented programmes and services for women and girls living in poverty and emphasized its programmatic approach to involve youth volunteers, enabling them to reach a growing number of young persons.

18. Capacity-building of key stakeholders was another important aspect of promoting a rights-based approach. OHCHR Uganda conducted three district-level training sessions with medical and other technical personnel on the application of the technical guidance. In 2016, OHCHR also strengthened the capacities of 25 civil society organizations to monitor, investigate, document and report on allegations of sexual and reproductive health and rights

[6] See also submissions by Cuba, Lebanon, Mauritania and Mexico.

[7] See submissions by Albania, El Salvador, Iraq, Mauritania, Mauritius and Oman.

[8] See submissions by Marie Stopes International, Swedish Association for Sexuality Education and Women Enabled International.

[9] See also submissions by Georgia, Sociedad Intercontinental de Derechos Humanos and Swedish Association for Sexuality Education.

violations to inform evidence-based policy advocacy and strategic litigation. Those organizations then conducted research on the status of maternal health in their regions, and the key findings were disseminated in 2017 in a regional workshop for local government officials.

19. In their submissions, the Democratic Republic of the Congo, Mexico, Portugal, Senegal, Turkey, UNFPA Burundi, Marie Stopes International, International Planned Parenthood Federation and Women Enabled International shared information about capacity-building and/or awareness-raising activities conducted with health workers, including on applying the human rights-based approach to maternal health and on respecting sexual and reproductive health and rights of all women, including women with disabilities.

D. Monitoring, review, oversight and remedies

20. Efforts to monitor, review and provide remedies in line with the technical guidance were emphasized by stakeholders in their submissions. Croatia, Czechia, Georgia, Honduras, Malta, Mauritania, Mexico and Slovenia highlighted how they had put in place monitoring and accountability mechanisms, such as: gender-sensitive data collection on maternal health; survey studies; national registers on reproductive health; and mechanisms for tracking and analysing maternal deaths and injuries. In its submission, Cuba also reported the practice of regular technical discussions meetings to study each maternal health case where there had been a complication in identifying when care fell short, training personnel and taking organizational and disciplinary measures when rights were violated. Mauritius noted the establishment of a fully functioning health information system, which included 100 per cent civil registration coverage and collected disaggregated data on sexual and reproductive health on a daily and systematic basis. Marie Stopes International emphasized how it had used participatory approaches to collect both quantitative and qualitative data about their programmes to identify and address gaps, including regular feedback and client exit interviews integrated into monthly evaluations.

21. In relation to human rights mechanisms, OHCHR Uganda had supported the Uganda Human Rights Commission in developing a public database to monitor recommendations and facilitate timely reporting to international, regional and national human rights mechanisms. The database included sexual and reproductive health and rights issues and had been rolled out with six pilot ministries, departments and agencies through trainings in the period 2016–2017. Human Rights in Childbirth also indicated its assistance to civil society actors preparing shadow reports and letters of support to international and regional human rights mechanisms.

22. In 2017, the Center for Reproductive Rights in Kenya released a public report on the detention and abuse of women seeking maternal health services, which was based on a 2015 High Court decision that had declared that fundamental rights had been violated.[10] Subsequently, in 2018, the Center supported the litigation of a pregnant woman who had been verbally and physically abused by hospital staff and left intentionally to give birth on the floor. The High Court found violations of her rights to health and dignity.

IV. Challenges for the implementation of the technical guidance

23. The many concrete examples of good practices highlighted above illustrate the significant progress that has been made over six years to raise awareness of and implement the technical guidance, although challenges remain. Despite the fact that more actors are familiar with the guidance, there is a clear need to continue efforts at widespread dissemination and increased awareness of the technical guidance and rights-based approaches more generally.

[10] Center for Reproductive Rights, "Detention and Abuse of Women Seeking Maternal Health Services: Fundamental Rights Violation" (Nairobi, 2017).

24. Multiple stakeholders reported on the challenges posed by stigma, stereotypes, sociocultural barriers or discriminatory practices and abuse associated with women's sexuality and reproductive health care, including by health workers. The particular impact this had on women and girls in situations of vulnerability and marginalization was also underscored.

25. Financial and human resources and infrastructure constraints continued to thwart the full implementation of the guidance, with civil society organizations often required to assist. In their submissions, the Democratic Republic of the Congo, Mauritania, Senegal and UNFPA Burundi reported hardships in garnering financial resources to advance maternal health and/or in ensuring access for women in remote or poverty-stricken areas. The National Human Rights Commission of Nigeria also noted challenges in addressing delays in access to adequate emergency obstetric care and overcrowded maternity wards. Mali, Mauritania, Sweden and the civil society organization Roda also highlighted shortages in the skills supply of health workers providing maternal health care, in particular at the community level.

26. Restrictive funding policies by donors, including on abortion, had an impact on the ability of civil society organizations to effectively address maternal mortality and morbidity using a human-rights based approach.[11] For instance, Family Health Options Kenya reported reduced resources for health programmes directed at marginalized women and girls in two counties as a result of changes in donor policy.

27. According to a number of submissions, there were challenges in ensuring adequate coordination in responses and in the systematic collection of accurate reliable data on maternal mortality and morbidity to inform policies and programmes.[12]

28. Addressing maternal mortality and morbidity as a human rights concern in humanitarian settings presents particular challenges that require dedicated analysis. Therefore, the remaining sections of the present report focus on the implications of a human rights-based approach to reducing maternal mortality and morbidity in humanitarian settings.[13] This non-exhaustive analysis points to the need for further work in this area.

V. Application of a human rights-based approach to humanitarian settings

A. Overview

1. Sexual and reproductive health in humanitarian settings

29. Women and girls of reproductive age constituted more than a quarter of 100 million people in need of humanitarian assistance in 2015.[14] In such settings, women and girls face much higher risks of maternal mortality and morbidity, and some sources suggest that over half of maternal deaths occur in such contexts.[15] The nature of these crises is increasingly complex and protracted and the average length of time spent in a refugee camp is 20 years.[16] Some young persons and children have never known life outside of crisis —

[11] Submissions by Swedish Association for Sexuality Education. See also PAI, "Access Denied: Uganda Preliminary Impacts of Trump's Expanded Global Gag Rule" (Washington, D.C., 2018); and International Women's Health Coalition, "Taking the Pulse of Trump's Deadly Global Gag Rule" (6 November, 2017).

[12] Submissions by the Democratic Republic of the Congo, El Salvador, Georgia, Mauritania and Roda.

[13] As the Human Rights Council recognized in its resolution 35/16, "humanitarian settings" include humanitarian emergencies, situations of forced displacement, armed conflict and natural disaster. Each type of emergency may have specific implications for sexual and reproductive health and rights, which is beyond the scope of the present report. However, the foundations of the human rights-based approach can be applied generally across all emergencies.

[14] UNFPA, *The State of World Population: Shelter from the Storm* (2015), p. 63.

[15] WHO, *Trends in maternal mortality 1990 to 2015* (2015), pp. 26, xi.

[16] *The State of World Population*, p. 14.

meaning that they have lived their entire lives in contexts of heightened risk. For them, a lack of access to sexual and reproductive health services and information has particularly grave consequences, including unintended pregnancy, early and forced marriage, sexually transmitted infections and the risk of gender-based violence.

30. Humanitarian crises exacerbate pre-existing forms of gender-based discrimination and violence, and create additional barriers to gaining access to services. In the face of extreme adversity and insecurity, women and girls face particular risks of further violence, including trafficking, sexual slavery, rape, forced pregnancy, harmful practices such as child and forced marriage, and intimate partner violence.[17] Cases have also been documented of pregnant women and girls being specifically targeted, attacked, raped and beaten, including while in detention.[18] In addition, due to the scarcity of resources and opportunities, some women and girls resort to survival strategies such as transactional sex. All of the above, as well as a context of limited access to services, further increase potential exposure to sexually transmitted infections, unintended pregnancies, unsafe abortions and maternal mortality and morbidity.[19] Where such human rights violations occur, by State and/or non-State actors, stigma and marginalization of survivors is commonplace, yet access for women and girls to accountability mechanisms or effective remedies remains uncommon.

2. Human rights obligations

31. International human rights and humanitarian law are complementary and mutually reinforcing bodies of law, sharing common objectives in that they seek to protect human life and dignity and prohibit discrimination. Human rights standards related to sexual and reproductive health and rights thus continue to apply in armed conflicts and other humanitarian settings.[20] Under strict conditions, States may derogate from specific civil and political rights in case of a "public emergency".[21] No similar clause exists for economic, social and cultural rights, and treaty bodies have clarified that in emergencies those rights continue to apply with the minimum core obligations remaining non-derogable.[22]

32. The human rights standards related to the right to sexual and reproductive health have recently been articulated by the Committee on Economic, Social and Cultural Rights in its general comment No. 22 (2016) on the right to sexual and reproductive health. The State obligation to ensure minimum essential levels of that right includes obligations to repeal or eliminate laws policies and practices that criminalize, obstruct or undermine access to sexual and reproductive health; to take measures to prevent unsafe abortions and to provide post-abortion care and counselling; to ensure all individuals and groups have access to comprehensive education and information on sexual and reproductive health; to provide medicines, equipment and technologies essential to sexual and reproductive health; and to ensure access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health. The Committee also recognizes the interdependence of that right with multiple

[17] Ibid., pp. 40, 47–55; and Security Council resolution 1820 (2008).

[18] OHCHR, "Interviews with Rohingya's fleeing from Myanmar since 9 October 2016", Flash Report (2017), available at www.ohchr.org/Documents/Countries/MM/FlashReport3Feb2017.pdf.

[19] Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (2015), p. 5; *The State of World Population*, p. 38.

[20] These obligations are laid out in previous reports of the High Commissioner, e.g., A/HRC/33/24 and A/HRC/27/20. See also OHCHR, Information series on sexual and reproductive health and rights, available from www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx.

[21] See article 4 of the International Covenant on Civil and Political Rights and Human Rights Committee general comment No. 29 (2001) on derogations from provisions of the Covenant during a state of emergency, paras. 4 and 11.

[22] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 47; Committee on the Elimination of Discrimination against Women, general recommendation No. 28 (2010) on the core obligations of States parties under article 2 of the Convention, para. 11, and No. 30 (2013) on women in conflict prevention, conflict and post-conflict situations, paras. 2 and 8; and OHCHR, *Protection of economic, social and cultural rights in conflict* (Geneva, 2015), paras. 12–15.

human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education and the prohibition of discrimination.

33. The Committee on the Elimination of Discrimination Against Women has explained that gender-based violence includes forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, and the abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services.[23] Furthermore, the Committee has recognized that women often experience increased sexual violence in conflict, that requires specific protective and punitive measures, and has explicitly called on States to ensure access to contraception, including emergency contraception, in humanitarian settings.[24]

34. International humanitarian law, which applies only in situations of armed conflict, contains a number of relevant legal obligations drawn from the Geneva Conventions, the Additional Protocols to the Geneva Conventions and customary international humanitarian law. At a minimum, States and parties to the conflict have a duty to provide special care for pregnant women and mothers of young children with regard to the provision of food, clothing, medical assistance, evacuation and transportation, and to ensure that the protection and care due to the wounded and sick is also provided to pregnant women.[25] This care must furthermore be provided and ensured without discrimination. Humanitarian law also emphasizes that the specific needs of women must be respected at all times, including to be protected against all forms of sexual violence.[26]

35. In the context of its women, peace and security agenda, the Security Council noted the need for access to the full range of sexual and reproductive health services, including regarding pregnancies resulting from rape, without discrimination,[27] and called on States to provide non-discriminatory and comprehensive health services, including sexual and reproductive health.[28] Finally, the 1951 Convention relating to the Status of Refugees includes the right of refugees to have access to health services equivalent to that of the host population, as part of the right to public relief and assistance.

3. Humanitarian programming, human rights-based approach and sexual and reproductive health and rights

36. At the beginning of an emergency, a range of United Nations agencies, donors and international and national civil society organizations work together with the Government to deliver humanitarian relief. Coordination between the actors and across sectors is a critical step in ensuring respect for the rights of affected populations, including the delivery of sexual and reproductive health services, and in identifying responsible actors for ensuring such rights. The Global Cluster Approach is a coordination system by which thematic clusters have a clear mandate established by the Inter-Agency Standing Committee and function at the global, regional and national levels, where they may be activated depending on the humanitarian crisis. Aiming to improve coordination and effectiveness, each cluster has a lead organization, accountable for the delivery of adequate humanitarian programming within a particular sector. There are 11 global clusters, each with their own functional components or areas of responsibility. While sexual and reproductive health and

---

[23] See Committee on the Elimination of Discrimination against Women, general recommendation No. 35 (2017) on gender-based violence against women, updating general recommendation No. 19, para. 18.

[24] Ibid. See also general recommendation No. 30 (2013) on women in conflict prevention, conflict and post-conflict situations, paras. 20 and 52.

[25] Geneva Convention relative to the Protection of Civilian Persons in Time of War, arts. 16–18, 21–23, 38, 50, 89, 91 and 127; Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the protection of victims of international armed conflicts, arts. 8 (a), 70 (1) and 76 (2); rule 134 of the customary international humanitarian law database of the International Committee of the Red Cross.

[26] See rules 119 and the commentary to rule 93 of the customary international humanitarian law database, available at https://ihl-databases.icrc.org/customary-ihl/eng/docs/home.

[27] Security Council resolution 2122 (2013).

[28] Security Council resolution 2106 (2013).

rights is not a cluster unto itself, the health and protection clusters, and particularly the sub-cluster on gender-based violence, address issues related to sexual and reproductive health.[29]

37. The Inter-Agency Working Group on Reproductive Health in Crisis[30] developed the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings,[31] which was revised and updated in 2018 and was in the final stages of publication at the time of issuance of the present report. Embedded in human rights standards and principles, the Manual provides authoritative guidance on reproductive health service provision during all phases of an emergency. Critically, it includes guidance on the implementation of the Minimum Initial Service Package, which identifies life-saving interventions and prioritizes implementation of the sexual and reproductive health services that are critically necessary to prevent morbidity and mortality. Integrated in the global health cluster guidance, it outlines a set of priority interventions to be implemented at the onset of an emergency, which should be in place within 48 hours through simultaneous and coordinated actions. That is then bolstered by longer-term and sustainable health-care solutions over time and aims to deliver on key objectives, including: maternal morbidity and mortality; sexual violence; sexually transmitted infections/HIV; unintended pregnancies, including the provision of voluntary contraception; and safe abortion care to the full extent of the law.

38. The Humanitarian Programme Cycle[32] sets out a series of actions to help prepare for, manage and deliver humanitarian response. It consists of five interrelated elements, including a needs assessment and analysis; strategic response planning; resource mobilization; implementation and monitoring; and operational peer review and evaluation. The policy cycle explained in the technical guidance — planning, budgeting, implementation, monitoring, review and remedies, and international cooperation — is comparable to the Humanitarian Programme Cycle. The technical guidance puts forth the concept of a "circle of accountability" that emphasizes that actions to ensure accountability need to happen across all stages of the policy cycle, not only in reaction to alleged violations. That concept is also applicable to the humanitarian programming cycle and can complement existing accountability frameworks in humanitarian contexts.[33]

39. A human rights-based approach to maternal mortality and morbidity in humanitarian settings supports the calls coming from within the humanitarian community for a holistic and integrated approach, which seeks to bridge the humanitarian-development divide. In many cases, the onset of crisis exacerbates already weak health systems, which were not meeting human rights standards in terms of sexual and reproductive health and rights. A holistic response would include attention to strengthening national health systems before, during and after crisis, and ensure they are not replaced by short-term measures when crisis hits.[34] This holistic approach also requires examining narrowly defined interventions and programming, which may result from funding and/or programmatic requirements, but which can also result in entrenching siloed paradigms and neglecting the experiences of certain categories of women and girls. For instance, programming for gender-based violence that provides access to comprehensive sexual and reproductive health services for victims of violence, while possibly excluding those who have not come forward as victims; or human rights monitoring that focuses narrowly on conflict-related sexual violence, neglecting to analyse human rights violations related to intimate partner violence or violations of sexual and reproductive health and rights. Increasingly, human rights and humanitarian advocates are calling for inclusive approaches that transcend dichotomous framings and place women and girls at the centre of response, capture the totality of every

[29] See submission by UNFPA Burundi, in which it noted the absence of a subsectoral working group on sexual and reproductive health as a challenge and the need for better coordination of interventions, also in relation to data collection and usage.

[30] See http://iawg.net/.

[31] Available at http://iawg.net/resource/inter-agency-field-manual-on-reproductive-health-in-humanitarian-settings-2010/.

[32] See https://interagencystandingcommittee.org/system/files/hpc_reference_module_2015_final_.pdf.

[33] See also Independent Accountability Panel, p. 12.

[34] See A/70/709, para. 110.

woman's and girl's experiences, which transcend the crisis context, and ensure a continuum of care in terms of access to services.

B. Key elements

1. Available, accessible, acceptable and quality comprehensive sexual and reproductive health care

40. As in other contexts, a human rights-based approach in humanitarian settings identifies who has rights (rights holders) and what freedoms and entitlements they have under international human rights law, as well as the obligations of those responsible for making sure rights holders enjoy their rights (duty bearers). It recognizes that sexual and reproductive health and rights are human rights, which must be upheld, even in humanitarian settings, and not matters of charity. In the context of humanitarian settings, the role of private actors is also pertinent, recognizing that the State, or occupying power, retains a duty to ensure that private actors do not engage in human rights violations.[35] It is important to note also that, under certain circumstances, in particular where an armed group with an identifiable political structure exercises significant control over territory and population, non-State actors are obliged to respect international human rights.[36] The present section explains the requirements of availability, accessibility, acceptability and quality, and how these human rights requirements may require further analysis in the context of humanitarian settings.

41. Humanitarian policies and programmes should ensure availability through a sufficient quantity and range of functioning sexual and reproductive health facilities, goods and services. This involves, for example, trained and skilled health-care staff, as well as comprehensive sexual and reproductive health services. Where crisis inhibits the ability of the State to provide comprehensive sexual and reproductive health services, the Minimum Initial Service Package, together with the core content of the right to sexual and reproductive health as articulated in general comment No. 22, is an important practice and starting point for determining which services should be prioritized. These services must be provided without discrimination, and involve the establishment and implementation of clear referral pathways and integrated approaches.[37] Attention to ensuring that individuals and their communities are aware that these services are available and where they can be accessed is also critical. Humanitarian settings complicate the ability to ensure the availability of services, necessitating particular attention to interventions, which can maximize efficiencies such as task shifting, or user-initiated interventions for health care.

42. Furthermore, sexual and reproductive services, facilities and information provided by both the public and private sector must be physically and economically accessible to all affected individuals and communities, including host communities, with a particular emphasis on identifying and ensuring access for women and girls in the most vulnerable and marginalized situations. This means ensuring that such services, and the underlying determinants, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including for women and girls with disabilities. Accessibility is a major challenge in crisis situations as infrastructure breaks down and the ability of people to move, especially women and girls, is restricted as a result of insecurity and imposed movement restrictions.[38] For example, although important initiatives are under way to ensure maternal and child health, after decades of conflict in the Democratic Republic of the Congo, the health-care system is severely damaged, leaving many health facilities

[35] See for example, United Nations Assistance Mission for Iraq (UNAMI)/OHCHR, report on the promotion and protection of rights of victims of sexual violence captured by ISIL/or in areas controlled by ISIL in Iraq (2017), para. 45.

[36] OHCHR, *International legal protection of human rights in armed conflict* (2011), pp. 23–37; and Committee on the Elimination of Discrimination against Women, general recommendation No. 30, para. 16.

[37] See also submission by UNFPA in the Democratic Republic of the Congo.

[38] See, on movement restrictions, in particular of pregnant women at checkpoints, A/HRC/10/35. Regarding a lack of access to services, see OHCHR, supra note 18, pp. 23 and 31.

without electricity or water, and without the capacity to deliver essential services such as emergency obstetric care.[39]

43. Accessibility also encompasses the right to seek, receive and impart information and ideas concerning sexual and reproductive health and rights. This information must be accurate and provided in an accessible format to everyone affected by a crisis, taking into account age, language and disability and other relevant factors. As the organization IPAS also highlighted in its submission, in addition to broad information and awareness-raising campaigns, young people in all contexts also require age-appropriate, culturally acceptable, evidence-based and reliable comprehensive sexuality education.

44. Given the above, all sexual and reproductive health services, goods, facilities and information must keep the individual health users and their experiences, views and needs central at all times. They must also be: scientifically and medically appropriate and of good quality; sensitive to gender and life-cycle requirements; designed to respect confidentiality and improve the health status of those concerned; and in line with medical ethics and culturally appropriate to the individual (acceptable). For instance, a full range of contraceptive options must be ensured, along with efforts to ascertain the preferred choices of women and girls, as programme experience in some countries suggest that women often opt for long-acting methods when they are available and of good quality. In most humanitarian settings, short-term methods of contraception appear to be the norm if contraceptive services are offered at all.[40] Importantly, paternalistic approaches by health workers, informed by personal ideology rather than health evidence, are contrary to human rights requirements, which rather value respect for the autonomous decision-making of women and girls about their sexual and reproductive health. Acceptability and quality also demand respect for the health user's privacy and confidentiality, including informing them how their information is kept confidential and ensuring availability of safe spaces for counselling, examination and treatment to promote informed decision-making free from coercion or the presence and influence of third parties.

45. Despite progress, the reality of humanitarian crises means that women and girls continue to face serious barriers in accessing quality services owing to collapsed health systems, prohibitive costs, lack of information and decision-making power, lack of privacy, insecurity, restrictions in movement and fear of further violence for seeking out care.[41] The Minimum Initial Service Package is often not fully implemented, and access for certain groups, such as adolescents remains a challenge.[42] For instance, women and girls, including survivors of sexual violence, may face insurmountable obstacles to gaining access to safe abortion services, due to misconceptions on the part of service providers about the legality of abortion,[43] or the view that abortion is not considered essential medical care.[44] In the context of sexual and gender-based violence, factors such as stigma, insecurity, few confidential safe spaces, mandatory reporting requirements and unclear referral pathways discourage victims/survivors from seeking appropriate medical care.[45] There also remains a lack of prioritization and related lack of awareness of the Minimum Initial Services Package among key actors, as well as challenges in terms of resources, logistics, siloed

[39] www.savethechildren.org/content/dam/usa/reports/advocacy/sowm/sowm-2014.pdf, p. 35; see also submission by UNFPA in the Democratic Republic of the Congo.

[40] *The State of World Population*, p. 65.

[41] Ibid., pp. 38–40; and submissions by WHO and International Planned Parenthood Federation.

[42] See, for example, submission by WHO; and Inter-Agency Working Group, *2017 Evaluation of the Use of Inter-Agency Reproductive Health Kits for Crisis Situations* (2017), pp. 14–16. Available at http://iawg.net/wp-content/uploads/2018/01/Report-on-the-Use-of-the-IARH-Kits_11.2017.pdf.

[43] According to UNFPA, "99 per cent of the world's population lives in countries where abortion is permitted under certain circumstances." *The State of World Population*, p. 68. See also, UNAMI/OHCHR, p. 46.

[44] See T. McGinn and S. Casey "Why don't humanitarian organizations provide safe abortion services?" in *Conflict and Health* (2016); A. Radhakrishan, "Protecting safe abortion in humanitarian settings: overcoming legal and policy barriers", in *Reproductive Health Matters* (Nov. 2017), pp. 40–47.

[45] See, for example, A/HRC/31/46 (2016), para. 38.

approaches and coordination, including effective referral pathways.[46] Moreover, the provision of health services is complicated by restrictions on movement — of both women and girls, including during pregnancy, as well as humanitarian actors delivering services.[47]

46. A human rights-based approach also analyses a programme cycle through the human rights principles of non-discrimination and equality, participation and empowerment, sustainability and international assistance, transparency and accountability.[48]

2. Non-discrimination and equality

47. Discrimination against women is a factor in the non-prioritization of those services that are required only by women, including those related to maternal health and sexual and reproductive health more broadly, reflecting societal hierarchies about who matters and who does not. This is further compounded by multiple and intersecting forms of discrimination, including on the basis of age, ethnicity, race, religion and migration status.[49] For example, access to contraception is often limited in humanitarian settings. Where such services do exist, access for adolescent girls and unmarried women and girls is especially difficult because of prevailing gender norms about sexual activity outside marriage in many contexts as well as the influence of attitudes of health workers and service providers.[50] In a similar vein, and as also emphasized by the Global Respectful Maternity Care Council in its submission, pregnant women and girls often experience mistreatment and abuse at both the individual and structural levels, which is often driven by factors such as poor infrastructure, stock-outs and stress, overwork and lack of pay of providers, among others.

48. Applying the principle of non-discrimination and equality therefore means paying particular attention to the women and girls who are most at risk of being left behind. It also helps recognize and address the root causes of violations of sexual and reproductive health and rights and gender-based violence in both the public and private spheres. For instance, in Brazil, the Zika virus outbreak had a particularly acute impact on young women and girls of colour, from the poorest region of the country.[51] The root causes of their vulnerability to Zika, and lack of sexual and reproductive choices, included not only the discrimination they faced based on sex and ethnicity, but also deprivations they faced based on their socioeconomic status and living conditions.

3. Participation and empowerment

49. Women and girls continue to be seen by many institutions primarily as inherently vulnerable victims in need of protection and passive beneficiaries of assistance. Yet women and girls express their agency in many forms, including as human rights defenders, health service providers and first responders, combatants or members of armed groups or resistance movements, environmental activists, survivors and active participants in both formal and informal peace processes.[52] Besides ensuring the effective management of humanitarian action that reflects the views, experiences and needs of women and girls, a human rights-based approach, such as principles for humanitarian action, recognizes that women and girls are entitled to participate in decisions that affect their lives, including in

---

[46] M. Onyango, B. Hixon, S. McNally, "Minimum Initial Service Package for reproductive health during emergencies: time for a new paradigm", in *Global Public Health* (2013), pp. 342–356. See also *The State of World Population*, pp. 43–44 and 68.

[47] See submissions by the National Human Rights Commission of Nigeria, WHO, Center for Reproductive Rights, International Planned Parenthood Federation, Marie Stopes International and Women Enabled International.

[48] See also Center for Reproductive Rights, "Ensuring sexual and Reproductive health and rights of women and girls affected by conflict" (New York, 2017), pp. 28–29.

[49] See for example, A/HRC/32/18, paras. 38–39.

[50] *The State of World Population*, p. 42.

[51] Human Rights Watch, Neglected and Unprotected The Impact of the Zika Outbreak on Women and Girls in Northeastern Brazil (2017), p. 8.

[52] See Committee on the Elimination of Discrimination against Women, general recommendation No. 30, para. 6.

relation to sexual and reproductive health and rights.[53] This could include their participation in camp committees and decision-making and coordination mechanisms that concern, directly or indirectly, sexual and reproductive health and rights.

50. Forming strong partnerships with and financially supporting local women's groups is also critical for effective health service delivery. This enhances understanding on how values, practices and beliefs impact sexual and reproductive health in a community and consequently assists with the design, implementation and evaluation of culturally acceptable and inclusive policies and programmes, while building trust with local communities and ensuring access.[54]

4. Sustainability and international assistance

51. International assistance should be aimed at strengthening the national health systems and supporting the State to fully resume and sustain its primary responsibilities as duty-bearer. It is also critical to support efforts to bridge the development-humanitarian divide. As has been observed by UNFPA, guaranteeing the sexual and reproductive health and rights of women and adolescent girls will go a long way towards achieving the goal of inclusive, equitable development, and can lead to more resilient societies, more capable of withstanding crises and rebuilding in ways that lead to even greater resilience.[55]

52. The sustainability of interventions will increase where there is involvement and ownership of affected communities and individuals to claim their rights and support for the capacity of national and local actors to meet their obligations. Capacity-building with national health service providers can be considered, including trainings on sexual and reproductive health and rights, task shifting in the health system serving humanitarian populations, and engagement of national and regional professional societies in affected areas.[56] Sustainability also demands increased attention to the ways in which crises exacerbate risks of particular individuals and populations.

53. The Inter-Agency Field Manual emphasizes the need for all humanitarian actors, including States, to work together and ensure a transition, as soon as possible, from the Minimum Initial Services Package towards the integration of comprehensive sexual and reproductive health services into primary health care. This would ideally be within 3–6 months but can also be within weeks. A human rights-based approach further stipulates that, when States and other actors are in a position to move towards comprehensive care for any particular aspect of sexual and reproductive health, including at the onset of an emergency, they should do so as expeditiously as possible.

54. Despite the upward trend of funding for reproductive health in emergencies, there are still large gaps in terms of: (a) gender-sensitive funding across all humanitarian sectors; (b) political commitment to increasing budgets for excluded groups; (c) meeting the need for minimum services; and (d) limited capacity and/or an unwillingness of some donors and Governments to commit resources towards sexual and reproductive health and rights in all phases of an emergency.[57]

5. Transparency and accountability

55. Human rights accountability cuts across the entire programme cycle and entails multiple, participatory and transparent forms of monitoring, review and oversight, including administrative, social, political, legal and accountability of multiple humanitarian actors. Besides judicial procedures, there are other mechanisms and processes to ensure accountability, including for example national human rights institutions, health

---

[53] Ibid. See also Sendai Framework for Disaster Risk Reduction (2015); Sustainable Development Goals (2015).

[54] ActionAid, "On the frontline: Catalyzing women's leadership in humanitarian action" (Johannesburg, South Africa, 2016).

[55] *The State of World Population*, p. 76

[56] Submission by WHO.

[57] *2017 Evaluation of the Use of Inter-Agency Reproductive Health Kits for Crisis Situations*, p. 15. *The State of World Population*, p. 14.

commissioners, democratically elected local health councils, public hearings, camp committees, needs and impact assessments, data collection and analysis, and community-based oversight of finances and quality of care at service delivery points.[58] Like health systems, mechanisms for accountability often break down in crisis settings, if they even existed prior to an emergency. More attention is needed to identify innovative and effective approaches to promote accountability, including social accountability, in humanitarian settings.

56. Independent review mechanisms, performed in a safe and ethical manner can play a fundamental role by identifying those most at risk of being left behind, addressing the root causes of violations and ensuring that everyone has equal access. This may include investigative bodies, such as commissions of inquiry and fact-finding missions mandated by various United Nations bodies, which can play a critical role in promoting an integrated agenda that recognizes and is responsive to the continuum of human rights violations suffered by women and girls in crisis settings. For instance, such bodies can provide critical analysis of trends concerning violations of sexual and reproductive health and rights, consider whether referral pathways and follow-up in practice are adequate and sensitive to the views, experience and needs of the individual concerned and whether effective remedies exist when sexual and reproductive health services fall short. Until now, concerns about human rights related to sexual and reproductive health have been rarely taken up, or only addressed in passing, in the work of such bodies.[59]

57. Reliable data on the accessibility, availability and appropriateness of quality sexual and reproductive health services for all affected women and girls remains rare.[60] In addition, there is a gap in data and effective documentation of the effectiveness of interventions, including a rights-based approach, and their follow-up and continuum of care after referrals.[61] Reasons hindering adequate data collection include difficulties in gaining access to all segments of society and disaggregating data, a lack of ensuring confidentiality, a shortage of funding and a resistance to integrated standardized approaches and coordination, including in methodologies.[62]

58. Women and girls affected by an emergency have a role to play in monitoring service delivery. In this context, awareness-raising and developing their capacity to claim their rights is essential. Accountability mechanisms should also be established within health-care institutions so that feedback from health users can inform reviews of service delivery, including by developing, implementing and monitoring an action plan in response. In addition, contextual data and analysis by humanitarian actors, including assessments that help inform their programming, could also be shared with women's groups to strengthen their demand for accountability.

59. Transparency in policies, programming and coordination across sectors is critical for effective accountability. Rights holders and duty bearers should have a clear understanding of, inter alia: who is providing which services; how such services are coordinated; why certain services are prioritized over others; the locations where they are provided and how to reach them; how, by whom and why certain services are funded; how long services will continue; what services aim to achieve and if there is an exit plan; whom services do not reach; and the reasoning behind each of those decisions.

---

[58] See http://governance.care2share.wikispaces.net/Social+Accountability.

[59] See, for example, the report of the detailed findings of the commission of inquiry on human rights in Eritrea, paras. 123–125, available from www.ohchr.org/EN/HRBodies/HRC/ColEritrea/Pages/ReportColEritrea.aspx; and A/HRC/25/63, para. 60.

[60] See in this context, OHCHR, *Guidance note on the application of a human rights-based approach to data collection* (2016), available from www.ohchr.org/Documents/Issues/HRIndicators/GuidanceNoteonApproachtoData.pdf.

[61] See for both cases, submissions by the Democratic Republic of the Congo, Mali, the National Human Rights Commission of Nigeria and WHO. See all Blanchet et al. "Evidence on public health interventions in humanitarian crises", *The Lancet* (8 June 2017).

[62] Submission by International Planned Parenthood Federation.

60. Finally, the principle of accountability ensures that rights holders may seek redress when duty bearers have not fulfilled their obligations. Remedies are not limited to court interventions, as national judicial systems may be significantly compromised, weakened or entirely inexistent. Access to effective remedies must recognize and remove the specific barriers women and girls may face in seeking justice. This includes establishing confidential and non-biased processes to receive and address complaints and make meaningful changes to services. Lastly, an effective remedy must also include gender-transformative, victim/survivor-centred and comprehensive reparations.

VI. Recommendations

61. The United Nations High Commissioner for Human Rights notes with appreciation the numerous initiatives stakeholders have undertaken around the world to implement a human rights-based approach to reducing preventable maternal mortality and morbidity. Given the guidance's value to complement and inform emergency preparedness and response in a world facing increasingly complex and protracted humanitarian crises, with disproportionate and devastating impacts on maternal mortality and morbidity, the High Commissioner recommends that the Council remain seized of this important issue. In particular, the High Commissioner notes that strengthened efforts would be needed in order to enhance understanding on how a human rights-based approach to eliminating preventable maternal mortality and morbidity can be operationalized in humanitarian settings.

62. The following recommendations are made to States, humanitarian actors and other stakeholders, as relevant:

(a) Disseminate and promote implementation of the technical guidance and related tools developed by OHCHR as widely as possible at the national and subnational levels, as well as the international and regional levels;

(b) Bring laws and policies concerning sexual and reproductive health, including international assistance policies, in line with international human rights standards;

(c) Include analysis on how the technical guidance has been implemented by the State when reporting to international and regional human rights mechanisms, including in the context of the 2030 Agenda and the World Humanitarian Summit;

(d) Ensure a more holistic integrated approach that places the individual woman and girl at the centre of humanitarian preparedness and response, and recognizes the need to overcome siloed approaches and fragmented programming;

(e) Prioritize full implementation of the Minimum Initial Service Package for Reproductive Health at the onset of humanitarian emergencies, with particular attention to women and girls in situations of vulnerability, and ensure a transition, as soon as possible, towards comprehensive sexual and reproductive health services;

(f) Establish clear referral pathways that place the individual health user and her views, experiences and needs at the centre, are known by affected populations, promote an integrated approach, and include attention to a continuity of care and follow-up;

(g) Ensure meaningful participation of women and girls in identifying and determining needs, priorities for funding and service, processes for access and delivery, and crisis response, in recognition of their agency;

(h) Fund and promote reliable transparent, collaborative and disaggregated data collection on the availability, accessibility, appropriateness and quality of sexual and reproductive health services for all women and girls of affected populations, including host populations;

(i) Consider the systematic integration of sexual and reproductive health and rights into the mandates of investigative bodies established by the Human Rights

Council, including commissions of inquiry and fact-finding missions, and promote an integrated agenda that recognizes and is responsive to the continuum of human rights violations suffered by women and girls in crisis settings and their consequences, including the displacement of populations and the living conditions in humanitarian contexts and settings;

(j) Integrate the concept of a "circle of accountability" throughout the humanitarian programme cycle, including through multiple, participatory and transparent forms of monitoring, review, and oversight, including administrative, social, political and legal;

(k) Ensure transparency of policies, programming and coordination across sectors and clusters in a humanitarian response, including by sharing accurate information provided in accessible formats to everyone affected by a crisis, especially women and girls.